		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042325

Facility Name: WESTSHIRE NURSING & REHAB CTR

Address: 5825 W. CERMAK ROAD (Number) CICERO (City) 60804 (Zip Code)

County: COOK

Telephone Number: (708) 656-9120 **Fax #** (708) 656-9128

IDPA ID Number: 36-4096965

Date of Initial License for Current Owners: 09/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHELDON NEIDICH
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	411	Intermediate (ICF)	411	150,015	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	485	TOTALS	485	177,025	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,516		1,991	10,507	8
9	SNF/PED					9
10	ICF	124,884	3,117		128,001	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	133,400	3,117	1,991	138,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.24%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 1,942

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	578,678	60,318	15,683	654,679		654,679		654,679			1
2	Food Purchase		499,877		499,877	(8,614)	491,263	(2,839)	488,424			2
3	Housekeeping	394,487	107,490		501,977		501,977		501,977			3
4	Laundry	139,188	50,034	4,225	193,447		193,447		193,447			4
5	Heat and Other Utilities			231,335	231,335		231,335		231,335			5
6	Maintenance	154,699	30,524	169,369	354,592		354,592	1,768	356,360			6
7	Other (specify):* Security	104,235		30,817	135,052		135,052		135,052			7
8	TOTAL General Services	1,371,287	748,243	451,429	2,570,959	(8,614)	2,562,345	(1,071)	2,561,274			8
	B. Health Care and Programs											
9	Medical Director			20,900	20,900		20,900		20,900			9
10	Nursing and Medical Records	3,489,735	237,656	10,027	3,737,418		3,737,418		3,737,418			10
10a	Therapy	207,191		9,872	217,063		217,063		217,063			10a
11	Activities	173,207	43,315	6,562	223,084		223,084		223,084			11
12	Social Services	216,805		5,308	222,113		222,113		222,113			12
13	Nurse Aide Training											13
14	Program Transportation			1,121	1,121		1,121		1,121			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,086,938	280,971	53,790	4,421,699		4,421,699		4,421,699			16
	C. General Administration											
17	Administrative	330,735		244,500	575,235		575,235	(80,000)	495,235			17
18	Directors Fees											18
19	Professional Services			207,848	207,848		207,848	6,300	214,148			19
20	Dues, Fees, Subscriptions & Promotions			173,301	173,301		173,301	(108,567)	64,734			20
21	Clerical & General Office Expenses	309,247	41,076	84,051	434,374		434,374	(10,050)	424,324			21
22	Employee Benefits & Payroll Taxes			955,974	955,974	8,614	964,588		964,588			22
23	Inservice Training & Education			4,130	4,130		4,130		4,130			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,084	1,084		1,084		1,084			25
26	Insurance-Prop.Liab.Malpractice			390,226	390,226		390,226	102,088	492,314			26
27	Other (specify):* MARKETING	57,523			57,523		57,523	(57,523)				27
28	TOTAL General Administration	697,505	41,076	2,061,114	2,799,695	8,614	2,808,309	(147,752)	2,660,557			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,155,730	1,070,290	2,566,333	9,792,353		9,792,353	(148,823)	9,643,530			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR #0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,801	110,801		110,801	628,857	739,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			153,439	153,439		153,439	1,602,787	1,756,226			32
33	Real Estate Taxes			791,215	791,215		791,215		791,215			33
34	Rent-Facility & Grounds			2,004,000	2,004,000		2,004,000	(2,004,000)				34
35	Rent-Equipment & Vehicles			133,704	133,704		133,704		133,704			35
36	Other (specify):* amortize software			20,407	20,407		20,407	5,180	25,587			36
37	TOTAL Ownership			3,213,566	3,213,566		3,213,566	232,824	3,446,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,418	130,373	179,791		179,791		179,791			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,538	265,538		265,538		265,538			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		49,418	395,911	445,329		445,329		445,329			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,155,730	1,119,708	6,175,810	13,451,248		13,451,248	84,001	13,535,249			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,458)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,839)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,050)	21		18
19	Entertainment		20		19
20	Contributions	(15,325)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(93,242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5-A	(135,755)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (276,669)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	360,670		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 360,670		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 84,001		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESTSHIRE NURSING & REHAB CTR

ID# 0042325

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,768	6	1
2	MARKETING SALARY	(57,523)	27	2
3	HUNTER MANAGEMENT FEES	(80,000)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(135,755)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,839)	0	0	0	0	0	0	0	0	0	0	(2,839)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,768	0	0	0	0	0	0	0	0	0	0	1,768	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,071)	0	0	0	0	0	0	0	0	0	0	(1,071)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(80,000)	0	0	0	0	0	0	0	0	0	0	(80,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,300	0	0	0	0	0	0	0	0	0	6,300	19
20	Fees, Subscriptions & Promotions	(108,567)	0	0	0	0	0	0	0	0	0	0	(108,567)	20
21	Clerical & General Office Expenses	(10,050)	0	0	0	0	0	0	0	0	0	0	(10,050)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	102,088	0	0	0	0	0	0	0	0	0	102,088	26
27	Other (specify):*	(57,523)	0	0	0	0	0	0	0	0	0	0	(57,523)	27
28	**TOTAL General Administration**	(256,140)	108,388	0	0	0	0	0	0	0	0	0	(147,752)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(257,211)	108,388	0	0	0	0	0	0	0	0	0	(148,823)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(19,458)	648,315	0	0	0	0	0	0	0	0	0	628,857	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,602,787	0	0	0	0	0	0	0	0	0	1,602,787	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(2,004,000)	0	0	0	0	0	0	0	0	0	(2,004,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	5,180	0	0	0	0	0	0	0	0	0	5,180	36
37	**TOTAL Ownership**	(19,458)	252,282	0	0	0	0	0	0	0	0	0	232,824	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(276,669)	360,670	0	0	0	0	0	0	0	0	0	84,001	45

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SOUTHVIEW	CHICAGO	EXTENDED CARE	EVANSTON	EMPL LEASING
				WESTSHIRE		
				HEALTHCARE		
				PROPERTIES	CICERO	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 2,004,000			$	$ (2,004,000)	1
2	V	30	DEPRECIATION		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	648,315	648,315	2
3	V	32	INTEREST		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	1,602,787	1,602,787	3
4	V	36	AMORT.-MORT COSTS		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	5,180	5,180	4
5	V	26	INSURANCE		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	102,088	102,088	5
6	V	19	ACCOUNTING FEES		WESTSHIRE HEALTH CARE PROPERTIES	100.00%	6,300	6,300	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,004,000			$ 2,364,670	$ * 360,670	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON NEIDICH	MEMBER	Administration	39.59	See Attached	35	63.60	Mngmnt Fee	$ 164,500	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 164,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WESTSHIRE HEALTH CARE PROPERTIES
Street Address: 5825 W. CERMAK RD.
City / State / Zip Code: CICERO, IL 60650
Phone Number: (708) 656-9120
Fax Number: (708) 656-9128

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 648,315	$ 0	1	$ 648,315	1
2	32	INTEREST	DIRECT	1	1	1,602,787	0	1	1,602,787	2
3	36	AMORT.-MORT. COSTS	DIRECT	1	1	5,180	0	1	5,180	3
4	26	INSURANCE	DIRECT	1	1	102,088	0	1	102,088	4
5	19	ACCOUNTING FEES	DIRECT	1	1	6,300	0	1	6,300	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,364,670	$		$ 2,364,670	25

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Realty of Ill		X	MORTGAGE	$145,008.00	11/22/99	$ 20,733,500	$ 20,354,264	11/39		$ 1,602,787	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL	INTEREST	REVOLV		1,500,000	REVOLV	0.0825	86,812	6
7	OMI	X		WORKING CAPITAL	DEMAND			221,000	DEMAND		43,885	7
8				INSURANCE POLICY							22,742	8
9	TOTAL Facility Related				$145,008.00		$ 20,733,500	$ 22,075,264			$ 1,756,226	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 20,733,500	$ 22,075,264			$ 1,756,226	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 711,831	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 751,523	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,692	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 751,523	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 791,215	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	601,700	8
	1998	647,367	9
	1999	644,987	10
	2000	711,831	11
	2001	751,523	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTSHIRE NURSING & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042325

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-29-202-004-0000	NURSING HOME	$ 105,290.22	$ 105,290.22
2.	16-29-202-005-0000	NURSING HOME	$ 105,290.22	$ 105,290.22
3.	16-29-202-006-0000	NURSING HOME	$ 210,580.44	$ 210,580.44
4.	16-29-202-007-0000	NURSING HOME	$ 119,871.47	$ 119,871.47
5.	16-29-202-008-0000	NURSING HOME	$ 210,490.95	$ 210,490.95
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 751,523.30	$ 751,523.30

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 130,527 B. General Construction Type: Exterior MASONARY Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 120,000	1
2					2
3	TOTALS			$ 120,000	3

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	485		1996	1972	$ 19,609,780	$ 502,815	39	$ 502,815	$	$ 3,205,446	4
5											5
6											6
7					WESTSHIRE HEALTH CARE PROPERTIES						7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1996	3,490	89	39	89		534	9
10	INSTALLED 13 PHASE			1997	3,440	88	39	88		488	10
11	FURNISHED & INSTALLED GENERATOR FOR ELEVATOR			1997	7,608	195	39	195		1,081	11
12	NEW HEATER			1997	19,950	511	39	511		2,832	12
13	DRIER VENT MODIFICATIONS			1997	14,985	384	39	384		2,128	13
14	DUCTWORK			1997	9,000	231	39	231		1,280	14
15	INSTALL NEW AMPERS			1997	3,650	94	39	94		521	15
16	TOILETS, SINKS, SHOWER EQUIPMENT			1998	37,587	964	39	964		4,699	16
17	REWIRE 15 ROOMS			1998	10,400	267	39	267		1,234	17
18	MASTER POWER PANEL, CONTROL			1998	5,994	154	39	154		712	18
19	DOORS			1998	2,941	75	39	75		328	19
20	INSTALL VENTILATION FOR ELEVATOR ROOM			1998	8,750	224	39	224		980	20
21	INSTALL RETURN PIPES & SINKS			1998	4,752	122	39	122		503	21
22	ACCESS PANELS			1998	1,378	35	39	35		144	22
23	DIETARY DOOR & FRAME			1998	2,042	52	39	52		215	23
24	MIXING VALVES			1999	5,000	128	39	128		453	24
25	DRAIN			1999	5,523	142	39	142		503	25
26	WATER METER			1999	8,998	231	39	231		818	26
27	FRAMES,DOORS			2000	10,451	380	27.5	380		966	27
28	EXHAUST FAN & FIRE DAMPERS			2000	4,600	167	27.5	167		425	28
29	BOOSTER PUMP SYSTEM			2000	18,000	655	27.5	655		1,665	29
30	MIXING VALVES			2000	4,215	153	27.5	153		389	30
31	HOT WATER SUPPLY SYSTEM			2001	8,748	318	27.5	318		490	31
32	PAINTING			2001	32,000	1,164	27.5	1,164		1,794	32
33	STORAGE TANK			2001	3,340	121	27.5	121		187	33
34	ELEVATOR REHAB			2001	9,465	344	27.5	344		531	34
35	RE-WIRE FIRE ALARM SYSTEM			2002	4,645	92	27.5	92		92	35
36	HOT WATER BOILER			2002	9,448	186	27.5	186		186	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LOBBY AIR CONDITIONING AND COMPRESSOR	2002	$ 7,594	$ 150	27.5	$ 150	$	$ 150	37
38	INSULATED GLASS	2002	3,275	65	27.5	65		65	38
39	DOOR REPLACEMENT	2002	4,490	88	27.5	88		88	39
40	PUMPS	2002	3,721	73	27.5	73		73	40
41	PIPING, BALL VALVE, AND FITTINGS	2002	5,491	108	27.5	108		108	41
42	HOT WATER HEATER	2002	2,000	39	27.5	39		39	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 19,896,751	$ 510,904		$ 510,904	$	$ 3,232,147	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 815,454	$ 87,677	$ 81,545	$ (6,132)	10 YRS	$ 392,601	71
72	Current Year Purchases	34,171	15,035	1,709	(13,326)	10 YRS	1,709	72
73	Fully Depreciated Assets							73
74	REL PARTY	1,455,000	145,500	145,500		10 YRS	945,750	74
75	TOTALS	$ 2,304,625	$ 248,212	$ 228,754	$ (19,458)		$ 1,340,060	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,321,376	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 759,116	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 739,658	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,458)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,572,207	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 87,497 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SEE ATTACHED		$	$ 46,207	17
18					18
19					19
20					20
21	TOTAL		$	$ 46,207	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs		$		$ 32,702	$		$ 32,702	1
2	Licensed Speech and Language Development Therapist		hrs				891			891	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				93,944			93,944	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					49,418		49,418	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): RENTALS							2,836		2,836	13
14	TOTAL				$		$ 127,537	$ 52,254		$ 179,791	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR **#** 0042325 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 211,255	$	1
2	Cash-Patient Deposits	6,670		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,063,038		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,431		6
7	Other Prepaid Expenses	379,034		7
8	Accounts Receivable (owners or related parties)	332,494		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,093,922	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	286,971		15
16	Equipment, at Historical Cost	957,099		16
17	Accumulated Depreciation (book methods)	(805,952)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 438,118	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,532,040	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 829,321	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,500,000		29
30	Accrued Salaries Payable	289,235		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,126		31
32	Accrued Real Estate Taxes(Sch.IX-B)	751,523		32
33	Accrued Interest Payable	8,396		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,400,601	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,400,601	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,131,439	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,532,040	$	48

***(See instructions.)**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,715,067	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,715,068	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(486,629)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(97,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (583,629)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,131,439	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,787,779	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,787,779	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,840	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 176,840	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,964,619	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,570,959	31
32	Health Care	4,421,699	32
33	General Administration	2,799,695	33
	B. Capital Expense		
34	Ownership	3,213,566	34
	C. Ancillary Expense		
35	Special Cost Centers	179,791	35
36	Provider Participation Fee	265,538	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,451,248	40
41	**Income before Income Taxes (line 30 minus line 40)****	(486,629)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (486,629)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,318	2,373	$ 86,724	$ 36.55	1
2	Assistant Director of Nursing	2,349	2,482	67,564	27.22	2
3	Registered Nurses	16,131	17,488	435,231	24.89	3
4	Licensed Practical Nurses	55,193	59,013	1,144,716	19.40	4
5	Nurse Aides & Orderlies	138,302	148,297	1,512,229	10.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,594	13,051	207,191	15.88	8
9	Activity Director	1,955	2,036	31,807	15.62	9
10	Activity Assistants	16,518	17,682	141,400	8.00	10
11	Social Service Workers	16,035	17,208	216,805	12.60	11
12	Dietician					12
13	Food Service Supervisor	12,865	14,880	237,837	15.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	42,068	45,079	340,841	7.56	15
16	Dishwashers					16
17	Maintenance Workers	10,504	11,023	154,699	14.03	17
18	Housekeepers	44,133	46,785	394,487	8.43	18
19	Laundry	13,606	15,482	139,188	8.99	19
20	Administrator	2,392	2,546	110,128	43.26	20
21	Assistant Administrator					21
22	Other Administrative	2,067	2,615	220,607	84.36	22
23	Office Manager	1,879	2,019	69,310	34.33	23
24	Clerical	15,051	16,498	239,937	14.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	13,075	14,346	168,347	11.73	31
32	Other Health Casupply/ nrsg clrk	6,450	6,783	74,924	11.05	32
33	Other(specify) security/mktg	13,825	14,503	161,758	11.15	33
34	TOTAL (lines 1 - 33)	438,310	472,189	$ 6,155,730 *	$ 13.04	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 15,043	1-3	35
36	Medical Director	O	20,900	9-3	36
37	Medical Records Consultant	N	8,887	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,140	10-3	39
40	Physical Therapy Consultant	L	3,605	10a-3	40
41	Occupational Therapy Consultant	Y	6,233	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	34	10a-3	43
44	Activity Consultant	E	6,562	11-3	44
45	Social Service Consultant	E	5,308	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 67,712		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY ANN WRIGHT	ADMIN	0	$ 110,128
ZINA WARD	OP DIRECTOR	0	220,607
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 330,735

B. Administrative - Other

Description	Amount
OMI - MANAGEMENT FEES	$ 164,500
HUNTER - MANAGEMENT FEES	80,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 244,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		207,848
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 207,848

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,103
Unemployment Compensation Insurance	58,079
FICA Taxes	458,770
Employee Health Insurance	276,921
Employee Meals	8,614
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,414
EMPLOYEE PHYSICAL EXAMS	805
PENSION/PROFIT SHARING PLANS	44,882
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 964,588

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	31,429
Health Care Worker Background Check	5,372
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	93,242
TRUST/FRANCHISE/CONTRIB/ETC	15,325
LICENSES & PERMITS	6,427
DUES & SUBSCRIPTIONS	21,306
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(15,325)
Less: Public Relations Expense	(0)
Non-allowable advertising	(93,242)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 64,734

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	6/99	$ 3,518	3 YRS	$ 586	$ 1,173	$ 1,173	$ 586	$	$	$	$	$
2	PAINTING/DECORATIN	6/00	3,547	3 YRS		591	1,182	1,182	592				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,065		$ 586	$ 1,764	$ 2,355	$ 1,768	$ 592	$	$	$	$

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR # 0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $19,408**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,701** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **265,538**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,614** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WESTSHIRE NURSING & REHAB CTR #0042325 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,043	
	REPAIRS & MAINTENANCE		640	
			0	15,683
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,225	
			0	4,225
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		58,426	
	ELECTRICITY		124,164	
	WATER		48,597	
	CABLE TV - LOBBY		148	
			0	231,335
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,602	
	PAINTING & DECORATING		1,388	
	BUILDING REPAIRS		29,357	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		81,379	
	ELEVATOR MAINTENANCE & REPAIR		42,610	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		7,040	
	FIRE SERVICE		2,993	
			0	
			0	
			0	169,369
7	**OTHER**			
	SCAVENGER		30,817	
	SECURITY SERVICE		0	30,817
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	20,900	20,900

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	8,887	
	PHARMACY CONSULTANT	XVIII B 39-2	1,140	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	10,027
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,605	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	6,233	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	34	9,872
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	6,562	
			0	6,562
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,308	
			0	5,308
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WESTSHIRE NURSING & REHAB CTR **#0042325** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,121	1,121
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	244,500	244,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,091	
	ADMINISTRATIVE CONSULTANTS	XIX C	139,000	
	PROFESSIONAL FEES	XIX C	49,757	
			0	207,848
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	93,242	
	EMPLOYEE WANT ADS	XIX F	31,429	
	CONTRIBUTIONS	VI 20 XIX F	7,170	
	DUES & SUBSCRIPTIONS	XIX F	21,506	
	LICENSES & PERMITS	XIX F	6,427	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	8,155	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	5,372	173,301
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		269	
	EQUIPMENT REPAIR & MAINTENANCE		4,790	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,050	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		6,277	
	TELEPHONE		57,394	
	MESSENGER SERVICE		5,271	
			0	84,051

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	458,770	
	UNEMPLOYMENT COMPENSATION	XIX D	58,079	
	WORKERS COMPENSATION INSURANC	XIX D	110,103	
	HOSPITALIZATION INSURANCE	XIX D	276,921	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,414	
	EMPLOYEE PHYSICAL EXAMS	XIX D	805	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	44,882	
	CHICAGO HEAD TAX	XIX D	0	955,974
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,130	4,130
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,084	1,084
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		390,226	390,226
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 2,566,333

WESTSHIRE NURSING & REHAB CTR
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	499,877
LESS SALES TAX	(2,839)
NET FOOD	497,038
TOTAL PATIENT CENSUS	138,508
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	415524
ADD # EMPLOYEE MEALS/DAY	20
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	7300

PATIENT MEALS	415524
ADD EMPLOYEE MEALS	7300
TOTAL MEALS/YEAR	422824
NET FOOD	497038
DIVIDE TOTAL MEALS/YEAR	422824
COST PER MEAL	1.18
TIME EMPLOYEE MEALS	7300
EMPLOYEE MEAL RECLASSIFICATION	8614